

FILED DEC 18 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. 42482  
10419  
Registrar's No.

BIRTH NO.

REG. DIST. NO.

318

PRIMARY REG. DIST. NO.

1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mississippi b. COUNTY Attala	
b. CITY (If outside corporate limits, write RURAL and give town) St Louis Mo		c. CITY (If outside corporate limits, write RURAL and give township) McCool Rural 823.0	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2605 N. Taylor Ave		d. STREET ADDRESS (If rural, give location) 8	
3. NAME OF DECEASED a. (First) Mary Smith (Type or Print)		c. (Last) Knox	
4. DATE OF DEATH Dec 4 1950		5. SEX Female 3	
6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	
8. DATE OF BIRTH April 5, 1853		9. AGE (In years last birthday) 97	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Ethel Mississippi		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Steve Smith		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE Pete Knox		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Luvania Austin	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.  I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Hypertensive heart disease</i>  ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b)  DUE TO (c)  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.  19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION  20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Nov. 25, 1950 to Dec. 4, 1950	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 443X		22. I hereby certify that I attended the deceased from November 25, 1950, to Dec. 4, 1950, that I last saw the deceased alive on Dec. 2, 1950, and that death occurred at 7:30 p.m., from the causes and on the date stated above.	
23a. SIGNATURE R. F. Brooks, M.D.		23b. ADDRESS 2746 1/2 Franklin Ave., St. Louis, Mo.	
23c. DATE SIGNED 12/5/50		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE 12/7/50		24c. NAME OF CEMETERY OR CREMATORY McCool Mississippi	
24d. LOCATION (City, town, or county) (State) Mississippi		25. FUNERAL DIRECTOR'S SIGNATURE Wm. Smith	
25. DATE REC'D BY LOCAL REG. DEC 7 1950		25. ADDRESS 4019 Washington	

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

.....  
working under my personal supervision.

Student .....  
Student Embalmer

Student Embalmer No. ....

Signed.....

Licensed Embalmer No. ....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.